Implementation of RBRVS Reimbursement Methodologies
Technical Specification Document

OVERVIEW OF RBRVS MODELING

The Medicare Resource Based Relative Value Scale (RBRVS) assigns Relative Value Units (RVUs) to services in three categories.

Physician Work RVU	as modified by…	Cost of Living Geographic Practice Cost Index (GPCI)
Practice Expense (PE) RVU	as modified by…	Practice Expense GPCI
Malpractice Insurance (MP) RVU	as modified by…	Malpractice Insurance GPCI

The basic formula to pay for a service in Medicare's RBRVS is as follows:

(Physician Work RVU * Physician Work GPCI) +
(Practice Expense RVU * PE GPCI) +
(Malpractice Insurance RVU * MP GPCI) =
TOTAL RVU

Total RVU * Conversion Factor = Total Medicare Payment

In 2010, Medicare has assigned RVUs to 8,779 unique CPT/HCPCS out of 15,054 total.

Services with RVUs Assigned	**Services with no RVUs Assigned**
Evaluation and Management	Case management and assessment
Surgeries	Anesthesia Medical and surgical supplies
Psychiatric services in-office	Alcohol and drug abuse treatment Crisis intervention
Screenings and vaccine administration	Vaccination products
	Drug administration (J codes)
	Dental procedures (D codes)
	Hearing aids (V codes)
	Laboratory tests

Medicare's RBRVS is named as such because, over time, the inputs for pricing moved from a system based on billed charges to a resource-based system.

1) History of RVUs and the RBRVS

Highlights

- January 1, 1992: Medicare moved to an RVU-based payment system using the three RVU components stated above. Initially, however, only the Physician Work RVU component was resource-based.
- January 1, 1999: Resource-based Practice Expense RVUs implemented (transitioned in over four years)
- January 1, 2000: Resource-based malpractice insurance RVUs implemented

Physician Work

- Greatest weight in the total RVU
- Maintained and updated by CMS with recommendations provided by the American Medical Association's (AMA's) RUC (Relative Value Scale Update Committee)
- Includes pre-, during and post-service professional work and considers time, technical skill, mental effort and judgment, and stress.
- Federal law requires that all RVUs be reviewed no less than every five years. The Physician Work RVUs were updated January 1 of 1997, 2002 and 2007.

Practice Expense

- Some CPT/HCPCS have two RVUs – one for services performed in the physician office and one for services performed in a facility.
- The AMA established a separate Practice Expense Advisory Committee (PEAC) to assist in recommending changes when the Practice Expense RVUs are up for review.
- CMS implemented a new methodology for measuring resources in Practice Expense RVUs. This is being transitioned in over a four-year period.

Malpractice Insurance

- Contributes a small portion to the total RVU (weight of about four percent of the total).
- Revisions were made to the MP RVUs effective January 1, 2005.

Geographic Practice Cost Indices (GPCIs)

- There are a total of 90 geographic areas in Medicare's RBRVS.
- The values assigned to each of the three GPCIs (Physician Work, Practice Expense, and Malpractice Insurance) differ substantially across regions.
- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that no region currently have a GPCI for Physician Work less than 1.0.
- The Affordable Care Act gave each state a floor of 1.0 on the Practice Expense GPCI.
- In Vermont, the GPCIs are the same for all regions in the state:
  Physician Work = 1.0; Practice Expense = 1.0; Malpractice Insurance = 0.489

Medicare Conversion Factor

- Currently = $36.8729, changed by Congress in June 2010, but effective through 11/30/10
- The BBA required that the Conversion Factor be reduced over time but it never has been. This annual legislation has come to be known as the "doctor fix".
- Effective January 1, 2010, the Conversion Factor was set to be reduced to $28.3895.

2) Vermont's Current Payment Methodology

Highlights

- Vermont's current rates to physicians and other professionals are not represented by a uniform methodology.
- Rates were set many years ago and have been updated sporadically and on a code-by-code basis.
- B&A's quick review shows that, when compared to Medicare's current rate, rates for individual codes vary from a low of 5% of the Medicare rate to a high of 200% of the Medicare rate.

Current state legislation requires that Evaluation and Management codes are paid at 100% of the 2006 Medicare rate. This does not mean, however, that the E&M codes are at the current Medicare rates. Comparing Medicare's 2006 rates to 2010 rates, many of these rates have gone up but some have actually gone down.

OVHA publishes a fee schedule with all the fees set under the current methodology. What is complicating to providers is that, over time, a patchwork of adjustments have been implemented that may be made to the published base fee. The result of these adjustments, in addition to the various modifiers that are submitted on claims which can also impact payment, result in a complicated formula in which it is difficult for providers to determine what they will actually be paid for services.